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Access to Assisted Reproductive Technologies

by Susan B. Apel, Professor, Vermont Law School[1]

Abstract: The use of assisted reproductive technologies (ART) has raised questions about patient access to these new means of reproduction. This article explores existing legal constraints on access, primarily within the United States, including federal and state legislation and professional regulation. The article also raises questions as to the appropriate role and form of law in resolving disputes over patient access. The author acknowledges the difficulties in the drafting and use of positive, substantive law, and concludes by suggesting that legal concepts embedded in legal procedure may be useful in the resolution of access disputes.

The widespread availability and use of assisted reproductive technologies (ART) throughout the world has raised many legal, social, economic and ethical issues. One such issue is patient access to these reproductive technologies. Who may take advantage of, and who is excluded from, the use of ART? Shall the practice be restricted to married, heterosexual couples only? Are age restrictions appropriate? Should patients be vetted—as they are in adoption proceedings–to determine whether they will be suitable parents? May fertility clinics refuse to offer their services to prospective patients who have been convicted of child abuse? What of the patient who is seen administering corporal punishment to her existing children in the clinic waiting room? Through what mechanisms are these questions currently being answered, and most importantly, what is the best way to make these determinations? Is positive law the best

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[1]Susan B. Apel, Professor, Vermont Law School. I am grateful to Professors Linda Smiddy of Vermont Law School, Carlo Casonato of the University of Trento, and all others who made possible the forum at which this paper was originally presented. I also thank my colleague, Professor Judy E. Stern of the Dartmouth Medical School for her helpful comments, and my husband, Keith Irwin, for his support. This article may appear as part of the published proceedings of the Second International Scholars Forum held in Levico, Terme, Italy in June, 2006.

remedy, and if so, whose rights and interests deserve consideration? Are other means such as professional regulation or some form of alternative dispute resolution preferable?

The problems surrounding access to assisted reproductive technologies seem to arise from the reality demonstrated by its title. Potential recipients do not make use of these technologies on their own; the reproduction sought through use of these technologies is, by definition and necessity, *assisted* through the intervention of physicians and other health care workers. In these cases, not only does a professional relationship exist between doctor and patient; many health care providers believe that they have a duty, since they are assisting in the creation of another life, toward the life that they are helping to create. This may give rise to what one study has called "access-to-services issues," defined as a "dilemma caused by the presence of behaviors or conditions in the patient that the provider finds to be so problematic for ethical or other reasons that the provider is uncomfortable treating this individual."[2]

As the previous examples demonstrate, the kinds of dilemmas faced are many and often overlapping. They may include certain moral judgments about the *status* of the individual as it pertains to parenting, e.g., precluding single or same-sex couples from access to ART because morally "correct" parenting requires heterosexual marriage. They may be a combination of such moralism as well as concern for the medical health of the patient and the welfare of the child. An example may be age restrictions that spring from cultural notions that women over a certain

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[2]Judy E. Stern et al., Access to services at assisted reproductive technology clinics: A survey of policies and practices, 184:4 Am. J. Obstet Gynecol 591, March 2001

age ought not to parent, and that increased maternal age presents medical risk to the pregnant woman (increased chance of gestational diabetes) and medical (increased chance of preeclampsia and premature birth) and social (older parents apt to die while child is still young) risk to the potential child. Other access-to-services issues may be seen as arising from perceived harm to the child from poor parenting, such as denial of services to those convicted of child abuse or neglect.

This paper will concentrate on access to services issues as they arise in the United States. Nonetheless, a brief look at how other countries are dealing with these issues is appropriate. Regarding marital status and sexual orientation, many countries have enacted legislation dealing with these two issues, the vast majority of countries requiring marriage or a "stable" heterosexual relationship.[3] New legislation in Italy restricts ART to couples of different genders who are either married or living together.[4] Some countries such as France, Finland, Australia[5] and South Africa permit single women and lesbian couples[6] access to ART. While Great Britain's Human

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[3] H.W. Jones and J. Cohen, International Federation of Fertility Societies (IFFS), Surveillance, Vol. 81, No. 5, Suppl. 4, Fertility and Sterility, Ch. 3, Marital status in ART, S19, and Table 3, S20, (May, 2004)

[4]V. Fineschi et al., The new Italian law on assisted reproduction technology (Law 40/2004), J. Med Ethics 2005; 31;536-539

[5] Jones and Cohen, supra at note 3. See also, McBain v. State of Victoria, FCA 1009 (28 July 2000), found at www.austlii.edu.au/cgi-bin/disp.pl/au/cases/cth/federal_ct/2000/1099.htm? (site last visited on March 30, 2006.)

[6]No reference made to male same-sex couples, who are all but invisible in the discourse on this topic.

Fertilisation and Embryology Act of 1990[7] does not specifically forbid single and lesbian women from use of ART, its "welfare of the child" provision, discussed below, could allow health care providers to discriminate against them if they deem it to be in the child's welfare.[8] Canada recently enacted a national Assisted Human Reproduction Act[9], which contains an affirmative anti-discrimination policy, stating that "persons who seek to undergo assisted reproduction procedures must not be discriminated against, including on the basis of their sexual orientation or marital status."[10]

Regarding the welfare of the child issues, many countries report that either by "statute, guideline or custom," there is a sense, although somewhat vague, that the welfare of resulting offspring ought to be considered.[11] The recent Canadian legislation declares in its opening Principles that "the health and well-being of children born through the application of assisted

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[7]Human Fertilisation and Embryology Act of 1990, Section 13(5) can be found at http://hfea.gov.uk. It states that "A woman shall not be provided with treatment services unless account has been taken of the welfare of the child who may be born as a result of treatment (*including the need of that child for a father*). .."(italics added). A recent White Paper authored by the British government's Department of Health in December, 2006 has recommended that this "need for a father" clause be removed. If the proposal becomes law, clinics would not be able to refuse treatment to single or lesbian women based only on their status. http://www.dh.gov.uk/assetRoot/04/14/13/15/04141315.pdf, p.10, No. 2.6 (Site last visited on February 21, 2007)

[8]Dr. Kirsty Horsey, Access to IVF, BioNews, www.bionews.org.uk/update.lasso?storyid=1752. (Site last visited March 30, 2006)

[9]Assisted Human Reproduction Act, http://laws. Justice.gc.ca/en/A-13.4/text.html (2004)

[10]AHRA, supra note 9, Principles (2)(e)

[11]Jones and Cohen, supra note 3, Ch.9, Welfare of the child, S33 and Table 9, S34

reproductive technologies must be given priority in all decisions respecting their use,"[12] although presumably it must be read as consonant with its other, anti-discrimination, provision. Great Britain has been acknowledged as the only country to take into account the welfare of the child by imposing national legislation, which requires that those offering ART must consider the welfare of the incipient offspring in decisions about to whom to afford ART services. The HFE Authority, the body set up to administer the HFEA, amplified the definition of the child's welfare in its Code of Practice, with recognition of 'the importance of a stable and supportive environment for any child produced as a result of treatment." The Code goes on to list factors that must be taken in consideration, such as "commitment, age, medical histories, ability to meet the needs of the child or children, any risk to the child, including that of inherited disorders, and the effect on any existing child of the family".[13] Over the past fifteen years of experience with this component of the law, there has arisen a new respect for the complexities of defining and putting into operation such a standard. Fertility clinic workers believed these guidelines to be difficult to interpret, or perhaps easy to misinterpret based upon a patient's social status and condition[14]. Consequently as recently as February, 2006, changes have been made to this aspect of the law, including a requirement that the fertility clinic who wishes to deny access to the patient under this provision must shoulder the burden of proof, that is, there is a presumption that

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[12]AHRA, supra note 9, Principles (2)(a)

[13]Jones and Cohen, supra note 3, Ch. 9, Welfare of the child, Analysis of Survey, S33.

[14]HFEA, Tomorrow's children: Report of the policy review of welfare of the child assessments in licensed assisted conception clinics, No. 3, Risk factors to be taken into account. S. See also HFEA Press Release, Improved welfare checks system will be better , fairer, and clearer for fertility patients, GPS and clinics http://www.hfea.gov.uk/PressOffice/Archive/1130975947/TomorrowsChildren.pdf

services should be provided unless the clinic can establish serious harm to the child. Factors for consideration have been streamlined, tending more toward conditions that pose a serious health risk to the potential child and moving away from social aspects.[15]

The United States

In the United States, several commentators believe that access to services issues must be dealt with carefully, framing the issue as one of presumptive reproductive liberty, where decisions concerning childbearing and childrearing often receive Constitutional protection. John Robertson[16] argues that coital and non-coital means of reproduction spring from the same moral and personal desire to have and raise children. Thus, the use of technology should not be used, in a legal or moral sense, to distinguish this form of reproduction from the traditional. In the United States, there are few restrictions on who may reproduce "naturally" and under what circumstances. There are no "tests" that these couples or individuals who desire to parent must pass before conception. Thus, couples and individuals are free to conceive under what many may deem deplorable circumstances: without marriage, without a partner, with the assumption of many medical risks to themselves and the future child, and even without resources, financial or other, to ensure effective childbirth and childrearing. In an amusing analogy, Robertson states that the right to read books is protected under the First Amendment, and applies with equal force to the sighted and to the blind. The fact that the blind must use artificial technologies such as

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[15]See HFEA, Tomorrow's children, Press Release, supra note 14.

[16]John A. Robertson, Children of Choice: Freedom and the New Reproductive Technologies, Princeton University Press, pp. 32 et seq,.(1994)

braille does nothing to distinguish their interest in free communication nor in the degree of constitutional protection afforded them.[17] So too, the infertile who must rely on technology to reproduce should enjoy the same protections as those who can reproduce in traditional, tech-free ways.

And yet Robertson concedes that procreative liberty, like all rights, is not absolute, and may be curtailed when substantial harm can be established by those who seek to restrict it. Several questions arise at this point, the most obvious being how to define substantial harm, and what level of proof may be needed. Further, when he speaks of constitutionally protected rights, Robertson is speaking of attempts by the *government* to curtail these rights, most probably in the form of legislation that would curtail access, e.g., laws that would restrict unmarried persons from using ART. He acknowledges that many fertility clinics are in fact *private* entities, and that "[B]ecause private IVF clinics have wide discretion in selecting patients for treatment, they may in most circumstances be legally free to set the criteria for selecting patients."[18]

The United States: Legislation

There is no federal legislation in the United States dealing with access to ART.[19] This

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[17]Robertson, supra note 16, at 39.

[18]Robertson, supra note 16, at 117.

[19]The Fertility Clinic Success Rate and Certification Act of 1992 is federal legislation dealing with ART but not with the issue of access as it discussed here. It is concerned with providing accurate information to consumers regarding the rate of successful pregnancies achieved by each clinic through its use of ART as well as certification procedures and standards for embryology laboratories. 42 USCA Sec 201, 263 (a) (Supp. 1994)

may be because health issues are most often reserved to the states. Yet individual states have been slow to provide legislation. Reasons for this may include the real or perceived difficulty in legislating in areas where the relevant science is not easily understood, deference to physicians and the recognition that the practice of medicine has been largely self-regulating,[20]the queasiness with which reproductive and sexual issues are discussed, the fear of trampling constitutionally-protected rights and the value of individual choice,[21] and the ever-present political ramifications that tie this issue to that of abortion and the conservative right.[22]

In the past two years, at least three bills have been introduced in state legislatures that deal directly with the issue of access to reproductive technologies. They are illustrative of the lack of consensus on this issue. The differences in the form and contents of the proposed legislation could not be more pronounced.

The first bill, NH H.B. 105 was introduced into the New Hampshire legislature in 2005. It was short and to the point, reading in its entirety that "No hospital or other facility licensed pursuant to this chapter which provided fertility treatment services shall deny such services to

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[20]President's Council on Bioethics, Reproduction and Responsibility: The Regulation of New Biotechnologies, March 2004, p.9 www. bioethics.gov,

[21]President's Council on Bioethics, supra note 20, p. 12; Nigel M. De S. Cameron, Pandora's Progeny: Ethical Issues in Assisted Human Reproduction, 39 Fam. L Q. 745, 748 (2005)

[22]President's Council on Bioethics, supra note 20, p. 8; Cameron, supra note 21, at 748.

any patient for any reason other than medical or payment reasons."[23] Its counterpart in the Indiana legislature was a twenty-one page document prepared for review by the state's Health Finance Commission[24] prior to introduction into the Indiana legislature. It specifically restricted the use of ART to married persons only, and required intended parents to seek an assessment from a licensed child placing agency before any ART services could begin. The bill detailed the factors that must be used in the assessment, which were modeled after existing procedures for assessing prospective adoptive parents, including "a description of individual participation in faith-based or church activities. . ." In order to be deemed the legal parents of the offspring, intended parents were required to initiate a separate parentage proceeding in the court, at which time the court would make a determination as to whether or not the petitioning couple were suitable parents. Those who had committed certain felonies were automatically disqualified. Criminal penalties for violating any section of the bill attached to physicians, patients, and any third party who committed deception in furnishing any information to the parentage proceeding. Neither of these bills got very far in the legislative process. In early 2006, yet another bill was introduced in the Virginia legislature to prevent single women from using ART. The bill subsequently failed.[25]

There may be some state law that could be construed to apply to ART, though more

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[23]2005 New Hampshire House Bill No. 105, N.H. First Year of the 159th Session of the General Court, available through Westlaw, 2005 NH. H.B. 105.

[24]Proposed Section 1. IC 31-9-2-9.5, Draft on file with author.

[25]Draft of HB 187 can be found at www.westlaw.com, 2006 WLNR 2196653. Failure of HB 187 is documented at http://leg1.state.va.us

general in nature. These include state civil rights laws, which often mimic federal civil rights legislation but which include additional categories of illegal discrimination beyond race, ethnicity and religion, such as discrimination on the basis of marital status and/or sexual orientation. At least ten states have these statutes that include both marital status and sexual orientation.[26] Whether the state prohibitions apply to fertility clinics is a troublesome issue. State legislation tends to follow the federal law in prohibiting discrimination in employment and in public accommodations. The law as to whether fertility clinics constitute public accommodations is subject to dispute. Hospitals have been held to be public accommodations in some instances, and not in others. Doctors' offices have been held not to be, as parenthetically, have those of lawyers.[27] Some states statutorily define public accommodations by listing exactly what entities are covered (amusement parks, hotels, restaurants, etc.), raising questions as to 1) whether hospitals are included and 2) if omitted, does the omission mean that the legislature intended its list to be restricted to only those enumerated establishments? In the state of New Hampshire, health care providers are specifically deemed to be public accommodations by statute[28]. A

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[26]States include California, (Governor approved as of 9/25/2005 Assembly Bill No. 1400(2005-2006 Reg. Sess.) which amended Civil Code Sec. 51 to expressly include both marital status and sexual orientation as prohibited bases of discrimination under the Unruh Act; District of Columbia, DC St. Sec 2-1402.31; Hawaii, HRS Sec. 368-1; Illinois, 775 ILCS 5/1-102; Maine, 5 MRSA Sec. 4522; Maryland, MD Code, Art. 49B, Sec. 5; Massachusetts. MGLA 151B, Sec.4; Michigan, MCLA 333.20201; Minnesota, MSA Sec 363A.02 and 363A.11; New Hampshire, NH Rev. St. Sec 151.21

[27]See generally 87 ALR 2d 120, Section 9

[28]NH Rev. St. Sec. 354-A:1

pending case in California[29] concerning alleged discrimination against a patient because of sexual orientation has yet to be decided on the merits, but thus far, it appears as if there is no doubt as to the coverage of the state discrimination act to both the fertility clinic and the physicians.

Other pertinent state laws are the newer generation[30] of legislative enactments called "Patients' Bill of Rights." Few of these exist. New Hampshire has such a law that forbids the denial of "appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, or source of payment, nor shall any such care be denied on account of the patient's sexual orientation."[31] Interestingly, the major hospital in New Hampshire, Dartmouth-Hitchcock Medical Center, makes note of the existence of this state statute and provides a summary of patient rights on its website, but it fails to include the above anti-discrimination provision in its summary.[32]

Model legislation has been proposed by the American Bar Association's Family Law Section. It deals obliquely with the issue of access by defining an "intended parent" to

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[29]North Coast Women's Care Medical Group, Inc. v. Benitez, 40 Cal. Rptr. 636 (Cal. App.4 Dist.)(March 14, 2006)

[30]I refer to these as "newer generation" because of legislation in the 1970s and 1980s in the United States that were often called Patients Bills of Right but had a different focus; they were concerned with protecting the rights and autonomy of patients in nursing homes.

[31]N.H. Rev. St. Sec. 151:21

[32]www.dhmc.org, see Patient Rights.

include both the married and unmarried.[33] Another proposed model act, seemingly drafted in an academic context for a scholarly conference on ART, is more forthright, forbidding discrimination against any prospective parent (but not gamete donor) on the basis of race, ethnicity, national origin, religion, as well as marital status and sexual orientation.[34]

United States: Professional Regulation

Self-regulation by the medical profession is another vehicle through which access to ART services is policed. The American Medical Association has taken the position generally that providers of health care should not discriminate against persons due to sexual orientation and has encouraged all medical practices and physicians to include "sexual orientation, sex or perceived gender" in any nondiscrimination statements.[35] (There does not appear to be a similar statement regarding marital status.) The American Society for Reproductive Medicine (ASRM)(along with its affiliate organization, the Society for Assisted Reproductive Technology (SART)) has issued written reports from its internal ethics committee on a number of issues regarding access to ART. One such report addresses the issues of judgments concerning the welfare of the

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[33]American Bar Association, Draft Model Act Governing Assisted Reproduction Technology, Section 102, on file with author

[34]Cotton et al, Model Assisted Reproductive Technology Act, Section 202, J. Gender, Race & Justice, Vol. 9, No. 1 (Fall, 2005).

[35]American Medical Association, Res. 414, A-04 and Res. 1, A-93; Reaffirmed: CCB Rep. 6, A-03, as reported in GBLT Policy Compendium, September 2005

child[36], and another of the use of family members as gamete donors and surrogates.[37] A recent publication addresses access to fertility treatment by gays, lesbians, and unmarried persons.[38] These reports are discursive in nature although they do provide conclusions and recommendations. The report regarding the welfare of the child concludes that fertility clinics "may withhold services from prospective patients on the basis of well-substantiated judgments that those patients will be unable to provide or have others provide adequate child-rearing for offspring." Further the report encourages fertility programs to develop written policies on this issue and to have decisions made jointly among the members of a program rather than a single individual. It also cautions against assuming inability to parent by those patients with disabilities.[39] The other report finds that use of family members is "generally ethically acceptable," although intergenerational gamete donation is "especially challenging," and "consanguineous gamete donations from first-degree relatives are unacceptable." [40] Two points need to be made with regard to these ethics committee reports. The first is that the

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[36]Ethics Committee of the American Society for Reproductive Medicine, Child-rearing ability and the provision of fertility services, Fertility and Sterility, Vol. 82(3) September 2004.

[37]Ethics Committee of the American Society for Reproductive Medicine, Family members as gamete donors and surrogates, Fertility and Sterility, Vol. 80(5) November 2003

[38]Ethics Committee of the American Society for Reproductive Medicine, Fertility and Sterility, Access to fertility treatment by gays, lesbians, and unmarried persons, Vol. 86(5), November 2006

[39]While not dealt with specifically in this article, the issue of discrimination against disabled patients in their access to ART is of concern in the disabled community. It raises issues under the Americans With Disabilities Act. See Carl H. Coleman, Conceiving Harm: Disability Discrimination in Assisted Reproductive Technologies, 50 UCLA L. Rev. 17 (2002)

[40]Ethics Committee for the American Society of Reproductive Medicine, Family Members, supra note 37

recommendations are simply that; they are not enforceable. Secondly, if there is, or will be, any enforceability, enforcement is limited to the members of ASRM, and more specifically with regard to assisted reproductive technologies, to members of the affiliate organization, SART. It is true the majority of fertility clinics in the United States belong to SART. To date, no fertility program has been expelled from membership for ethical violations for failure to follow relevant guidelines.[41] Moreover, it is unclear to what extent membership in SART is critical, or advantageous to these programs; it is unknown whether the public understands the importance of seeking a SART-member program when it looks for ART services.

United States: Practice

In the absence of law, decisions regarding access to ART are made by fertility clinics and health care professionals. In the only published survey of ART clinics on this issue[42], it was determined that written policies on access to services existed in only 40% of ART clinics, and that "universal agreement was not found on any issue." Moreover, when asked whether the written policies were actually followed, 30% answered no. Regarding marital status and sexual orientation, 79% of the responding clinics treated single women and 74% lesbian couples.

It is in the consideration of factors commonly associated with the welfare of the child that the practice of clinics was most disparate. Responding to specific questions, 27% stated that they

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[41]Lyria Bennett Moses, Understanding Legal Responses to Technological Change: The Example of In Vitro Fertilization, 6 Minn. J. L. Sci. & Tech. 505 (2005), note 201 citing Jones and Cohen, supra note 3.

[42]Stern et al., supra note 2.

treat patients with a history of schizophrenia, 10% treat patients who use alcohol excessively, and 7% treated patients who had HIV. It is unclear whether the refusal of treatment in the above categories was motivated by a concern for the patient' health, the welfare of the child, a combination of the two, or for other reasons. Even more fascinating (and unfortunately too lengthy to include in its entirety in this paper) were the responses of ART clinics to specific ethical dilemmas posed by the researchers. As but one example and to give the flavor of the ethical issues that arise is the first scenario (Scenario A) presented to the clinics, which is as follows:

> A 48-year old man who has had both testicles removed as a result of a rare testicular cancer would like to have a child with his newly-wed wife of 25. He would like your clinic to establish the pregnancy using donor insemination with sperm of his 23 year old son. Will you perform the inseminations?

The percentage of clinics who responded "yes" was 44.3%. 55.7% responded "no". Major risks (and therefore reasons) cited by those who said "no" included psychological injury to the son, to the child, or to the family structure.[43]

The conclusions drawn by the researchers in this study are that "[C]linicians felt conflict between a desire to respect patient autonomy and their discomfort over the risk associated with the procedure. They raised concerns about the misuse of medical technology. Attempts to

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[43] Judy. E. Stern et al, Determining access to assisted reproductive technology: reactions of clinic directors to ethically complex case scenarios, Human Reproduction, Vol. 18, No. 6, pp. 1343-1352 (2003). Eight different scenarios, of which the above is the first, were presented to the respondents.

resolve complex issues through negotiation and compromise were common."[44]

The United States: Process

The conclusion in the Stern study that "negotiation and compromise" are common methods of resolving access issues raises a number of questions. Presumably this means "negotiation and compromise" between the clinic and the patient. Clinicians presented with the above Scenario A, for example, might talk about their misgivings with the patient, or might try to engage the patient in a discussion of the pros and cons of the proposed arrangement. Perhaps in doing so all of the parties will jointly decide whether to go ahead with the procedure or not.

In the absence of negotiation and compromise, however, it is the clinic's decision whether or not to provide services. This could be accomplished through having written policies that are followed, or could be made on a case-by-case basis. The decision could be made by an individual–the clinic intake worker, or a physician or other health care professional–or by a group after informal discussion.

Most hospitals have ethics committees that could take on these kinds of issues as they arise. In the Stern survey, approximately 36% of ART clinics said that they used ethics committees from time to time to help to resolve access issues.[45] At least in theory, anyone–including the patient–can request an ethics consultation. The advantage of using the ethics committee is that it removes the dispute from those most intimately involved, and places

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[44]Stern et al, supra note 43, at 1343.

[45]Stern et al., supra note 2

the issue before a new–and supposedly neutral–audience that is skilled in making ethical determinations.

On the other hand, one must not idealize the average ethics committee by imbuing it with wisdom and knowledge that it may not possess. One commentator noted that the American Society for Bioethics and Humanities (ASBH) developed a list of minimum competencies necessary for ethics consultation, which included ". . . 1)ethical assessment skills, 2) process skills, and 3) interpersonal skills"[46], and then set out to measure the capabilities of existing ethics committees. Based upon a sample of approximately forty ethics committees in the state of Maryland, the author concluded that ". . .the majority of ethics committee members identified as able to perform consults had no formal educational preparation in bioethics and nearly one-third had received no inservice or out-of-hospital ethics consultation education."[47] Thus, whether or not an ethics committee consultation adds anything of value to the deliberations concerning access issues appears to depend on the luck of the draw. In any event, even assuming competence, ethics committees offer only a consultation and opinion, and are not adjudicative nor binding on participants.

The United States: What Change Is Possible? What Change is Desirable?

It is precisely the "assisted" and the "technology" components of ART that has created a

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[46]Diane E. Hoffman et al, Are Ethics Committee Members Competent to Consult?, J. of Law, Medicine and Ethics, 28, No. 1 (2000), pp.30-40.

[47]Id.

new form of reproduction heretofore unknown to the law. Historically, couples have reproduced without the intervention of a third party who controls the technology that makes conception possible. When confronted with something new, the law combs through existing legal tenets in the hope of finding an analogous situation to which there is a (relatively) clear application of the law. Difficulties arise when more than one analogy is found. In the present case, ART can be said to resemble coital reproduction; it might also resemble the adoption of a child. Certain forms of ART are much more like natural reproduction in that they involve the use of a couple's own genetic material. Often, any embryos created in vitro are placed in the womb of the mother-to-be, who carries the child until birth. Delivery of the child is the same as that of naturally conceived children.

What of the second analogy–that of adoption? To start, all forms of ART resemble adoption because they involve the interjection of a third party–the physician in the fertility clinic or the social worker in the adoption agency. Moreover, just as certain kinds of ART are more like coital reproduction, others are closer to that of adoption. Consider the situation in which neither of the parents is genetically related to the child, i.e, egg and sperm have been donated by individuals other than the prospective parents. The child may be gestated by a surrogate.[48] Is not the specter of the prospective parents awaiting the birth of that child similar to incipient adoptive parents awaiting the birth of a child of an unwed teenage mother (for example) remarkably similar? And yet still there is a difference in that the prospective parents in the ART situation have been active participants in the creation of the child, not just bystanders to the conception

[48]In re Marriage of Buzzanca, 72 Cal. Rptr. 2d 280 (App.Ct. 1998)

who reap the benefit afterwards through an adoption procedure.

In the United States, the choice of analogy leads to greater or lesser involvement of the law, and different legal standards. If one determines that ART is more closely aligned with coital reproduction, far less legal involvement will ensue. The right to procreate and the right of privacy has thus far shielded sexual reproductive activity and kept the law at bay.

The United States: Cui Bono?–Who Benefits?

Should there be more legislation on the issues of access to ART? One commentator says the following:

"Our intuition that the law faces problems following the introduction of a new technology is correct, and is reflected in the metaphors of law struggling to keep up. However, the reflexive response that legislation is required to facilitate the law's adaptation to technological change may be wrong; legislation is inferior to the alternatives in some circumstances. In some cases, there may be benefits in adopting a "wait and see" approach. . .[A]wareness of the benefits of these alternatives is important in weighing proposals for reform. [49]

Cui bono? Who would benefit from such legislation? All players in the ART forum might prefer some certainty. With regard to the issue of access of single persons and same-sex couples to ART, legislation would be beneficial to those prospective patients, but only if the content of the legislation followed the Canadian model, which specifically forbids discrimination

[49]Moses, supra note 41.

on these bases. In the United States, it is difficult to predict whether state and/or federal legislation in this area would be permissive or restrictive. Mixed messages abound, as the media carry reports of greater participation by both of these groups in ART; yet generally, the conservative right is busy convincing state legislatures to ban marriage between same-sex couples. Restrictive legislation on these two issues would be harmful to those patients seeking ART services. The status quo most likely favors patients. While it is true that some fertility clinics are turning away single persons and same-sex couples, the Stern study shows that the majority are accepting of such patients into their practices. Moreover, at least two factors may keep discrimination to a minimum: 1) ART is not just a medical science but a business.[50] And in the United States, it is a competitive business. Fertility clinics seek to attract patients, not to repel them. 2) It appears that the medical establishment is fearful of being sued, or at a minimum, sees litigation as a drain on its reputation and resources. Whether or not a case of discrimination is successful, the mere possibility of a lawsuit may influence fertility clinics to accept rather than reject patients on the basis of status.[51]

What of other patients, those for whom access issues arise not from marital status or sexual orientation, but from a physician's judgment that to proceed with ART will harm the child-to-be for other reasons? There appears to be two reasons why legislation in this area

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[50] Debora L. Spar, The Baby Business: How Money, Science and Politics Drive the Commerce of Conception, Harvard Business School Press, Boston, MA (2006).

[51] I thank my colleague, Susan L. Crockin, Esq. for this insight. In my own informal conversations with doctors, I agree that they tend to overestimate the availability and strength of many discrimination claims.

would not benefit these patients. First, the law will likely recognize the constraints, even if self-made, of the physician who believes that s/he must act ethically according to his/her principles, including those toward a child that is the result of the ART process. And legally and ethically, doctors–like lawyers–are not required to form a patient-client relationship with everyone who asks. Where such legislation does exist, as in Great Britain, the law is plain in its recognition of the physician's duty toward the child. Thus, legislation in this area is more likely to formally recognize the welfare of the child as a factor upon which physicians may decline to provide ART services to certain patients. The second problem is simply one of scope and legislative drafting. Aside from the concept of "the welfare of the child", it is impossible for a legislature to imagine all of the possible objections that may arise to the provision of ART services. Would the example of the father who wished to impregnate his new wife with the sperm of his adult son be one that legislatures would have contemplated? And what other issues might arise that cannot be predicted? It is unlikely, then, that patients would benefit from legislation that would give them some sort of positive right in this regard, simply because drafters could never come up with a complete list.

The medical establishment–even while it may claim an affinity for certainty–would probably prefer the status quo, which is non-existent legislation and incremental self-regulation. Self-regulation has the advantage–to the regulators–of making the policy determinations that they think best, and by which their conduct will be judged. Self-regulation is less unwieldy, able to be modified as necessary and requiring the participation of a relatively smaller number of persons than that contained in a legislative body. However, self-regulation has been criticized as self-

serving as well as lacking in transparency[52]; a different criticism is also that the medical establishment may have expertise in regulating the medical and scientific aspects of ART, but that it has little if any knowledge or ability to judge socially complex issues like parenting ability or the welfare of a child.[53]

Thus far, with the exception of legislation that might empower single women and same-sex couples by affirmatively prohibiting discrimination against them in access to ART, positive law appears to offer little that would benefit physicians, patients, and children-to-be. That being said, law may have something to offer in the manner in which decisions regarding access are made.

The United States: Beyond Substance

If the substance of the law with regard to access is too difficult or undesirable to create and implement, perhaps the law could more profitably turn its attention elsewhere. One might begin by turning away from substance for the moment and considering whether the law could improve the process by which these issues of access are decided.

One of the criticisms of the way in which most decisions concerning access are made is lack of transparency.[54] Specifically, health care providers may choose to exclude the single

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[52]Moses, supra note 41.

[53]Stern et al, supra note 2.

[54]Moses, supra note 41.

mother, the same-sex couple, or the otherwise "inappropriate" patient within the privacy of their own thoughts, or perhaps, within the privacy of their own offices in an exchange of ideas among a small number of colleagues. Even the use of ethics committees may be carried on in relative obscurity, especially from the prospective patients. Accordingly, the law might help to bring transparency to this process by requiring, first and foremost, that clinics have policies on access, that they be in written form, and that they be made available to patients at all times. Recall that the studies done by Stern et al. found that written policies were found at only 40% of clinics. The requirement of written policies does not underestimate the difficulty of anticipating all potential access issues any more than is true for legislation in this area. However, to the extent possible, clinics should be required to reduce to writing what their standards are. Certainly this would have the incidental–but critically important–effect of helping clinic personnel to discover, understand, and communicate their own thoughts among themselves on these issues. The critically important legal construct of notice–availability of this information to patients-- will allow them to know that such decision-making will be part of their experience if they choose to avail themselves of the clinic's services. A commitment to written principles or standards will also provide accountability.[55]

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[55]In the United States, a somewhat analogous controversy exists concerning whether or not pharmacists are required to fill any prescription presented by a patient. Most notably, this issue has arisen in conjunction with the drug known as Plan B, viewed by some as a contraceptive and by others as an abortifacient. Particularly for those who regard this as means of abortion (although there are cases in which pharmacists have also opposed filling prescriptions for contraception in certain circumstances such as for unmarried women), pharmacist have invoked a "conscience clause" to support claims that they may do as they see fit. One response that has taken no stand on the ultimate issue but which may be helpful, is that pharmacies must have policies and must advertise what contraceptives are kept in stock and which, such as Plan B, are not. See Illinois Gov. Blagojevich Proposed Order for Pharmacies to Post Signs Detailing Contraceptives in Stock, http://kaisernetwork.org (site last visited June 20, 2006).

After notice, of course, is the opportunity to be heard. Lack of transparency does not mean only that decisions are made in obscurity; it means that some persons–i.e, patients–may be excluded from the decision-making process. Particularly when health care providers are making decisions concerning the appropriateness and/or the ability of someone to become a parent, it is essential that the person whose interests are being most affected should have the opportunity to be heard on the issue. This is not just a procedural nicety. If, for example, the clinic is considering turning away a patient because she is a single individual rather than part of couple, she might be able to offer factual information that is relevant to the issue: future marriage plans, presence of other family members to offer support to the child, economic security. If better decisions are made when all facts are considered, a patient's opportunity to be heard can provide access to factual information that would otherwise be overlooked.

A third process issue that the law may have to offer is taken from the law's experience with alternative dispute resolution (ADR). Rather than making a decision concerning access and then presenting the decision to the patient, clinics would do well to consider other ways of resolving access disputes. One such method already exists in some cases, in that a physician who wants to deny access may simply turn the patient over to another physician for whom the access dilemma does not exist, or refer a patient to another clinic with different access criteria. But more consideration of process is called for here. One example, easily accomplished, would be for the patient to sit in and actively participate in any meetings of the ethics committees when her case is being discussed. One author notes her own experience with a retooled ethics committee which "ensured that participants' opinions, interests, and emotions were elicited,

acknowledged, and summarized."[56] One assumes that "participants" includes the patient. The composition of the committee could be looked at to ensure a multiplicity of perspectives, including professionals from various disciplines, including a lawyer. The internal process of such a meeting might benefit from further scrutiny–for example, perhaps the presence of a mediator would be of use. One commentator has suggested that the generic ethics committee will not do at all, and has proposed ARTECs–assisted reproductive technologies ethics committees–composed of individuals who are particularly knowledgeable about ART issues.[57]

While the presence of a mediator on a hospital ethics committee might be one way of improving committee dynamics, one might eschew the ethics committee in favor of actual mediation. This is not to underestimate the skepticism with which mediation has been received in the health care profession. One commentator states that "the best escape from litigation–alternative dispute resolution (ADR)–including mediation–has, to date, been poorly received in the field of medicine."[58] Yet the authors hold out hope, claiming that the special circumstances of medical culture call for a special form of mediation, akin to cross-cultural mediation, and that education about mediation could yet make this an invaluable tool in the health care context[59]. I would add that much of the literature in this area stems from the already

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[56]Virginia L. Morrison, Heyoka: The Shifting Shape of Dispute Resolution in Health Care, 21 Georgia State Univ. L. Rev. 931, 940 (2005)

[57]Elizabeth S. Ginsburg, M.D., 9 J. Gender Race & Just. 319 (2005)

[58]Marc. R. Lebed and John J. McCauley, Mediation Within the Health Care Industry: Hurdles and Opportunities, 21 Georgia State Univ. L. Rev. 911, 912 (2005)

[59]Id. at 913

polarized situation of medical malpractice, where some harm has already occurred and doctors and patients and lawyers feel adversarial as a result. Mediation in the access to ART area may be different and could act in a more preemptive fashion rather than after a harm has already occurred.

Lastly, one could consider something akin to the burden of proof in decision-making. In its recent revision of consideration of the welfare of the child, Great Britain has done just that by acknowledging a presumption in favor of the patient's receipt of services. Thus a patient–single, homosexual, poor or otherwise seen as disadvantaged when it comes to parenting–does not have to argue that she is worthy. The provider must shoulder the burden of proving that there exists sufficient reason for refusing to provide services, consistent with the welfare of the child. If the concerns are related to medical risk, physicians–who presumably have some expertise in this area–would have to provide data in support of their risk assessment. If the problem is more of a social issue, similar data would need to be marshaled. This is an area in which physicians are less knowledgeable and skilled. "Medical doctors usually do not receive training in determining psychosocial risk and data may not be readily available to enable such risk to be assessed. In these cases it may be hard to differentiate assessment of risk from simple opinion or prejudice."[60] Stern goes on to acknowledge that in the aforementioned Scenario A, that of the intergenerational sperm donor, there is no scientific data about the effects of sperm donation under these

[60]Stern et al, supra note 2

circumstances.[61] That being the case, fewer individuals are likely to be turned away for social reasons, which correlates with the anticipated, and preferred, outcome under the new revisions to the HFEA in Great Britain.

Conclusion:

The role for law in issues of access to reproductive technologies is a complex one. In dealing with issues of substance, countries other than the United States have taken bold measures that, from the patient's perspective, are either restrictive or inclusive. It is unlikely that such national law will emerge in the United States. Individual states may have some existing law that could apply to access issues; whether they choose to go further and legislate specifically on access to ART remains to be seen. The political underpinnings of such law may be predictive of the content of such legislation, but which political view legislators are willing to advance is less predictable. Self-regulation within the medical profession is at the moment the most viable means of controlling access issues, leaving less need for legislation. Finally, while the role for substantive law may be muted, legal concepts embedded in legal procedure, including ADR, have something to offer to this difficult problem of resolving access disputes.

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[61]In a similar vein, the issue of advanced maternal age and ability to parent is often perceived negatively. One actual study shows otherwise. See A.Z. Steiner et al, Parenting Issues Among Women of Advanced Reproductive Age: Does Age Really Matter?, 85 Fertility and Sterility, Supp. 2, O-7, April 2006